



Department of Health  
Three Capitol Hill  
Providence, RI 02908-5097  
TTY: 711  
[www.health.ri.gov](http://www.health.ri.gov)

June 24, 2019

**Re:** Client Case Id:

**DOB:**

Dear colleague,

Please be informed that according to the Rhode Island Department of Health (HEALTH) Healthy Homes and Lead Poisoning Prevention Program's laboratory reporting system, the above child had a capillary screening test result of  $\mu\text{g/dL}$  on and has not had a report of a venous follow-up test within the time period specified below. If you have additional information indicating that this child, in fact, received a venous confirmation test, please let us know by calling [Staff Member] at [Staff phone].

The U.S. Centers for Disease Control (CDC) and the Department of Health recommend the following timetables for confirming capillary screening results with a venous sample:

<u>BLOOD LEAD LEVEL</u>	<u>TIMETABLE</u>
<4 $\mu\text{g/dL}$	No Follow up Needed
5-19 $\mu\text{g/dL}$	Within 3 Months
20-44 $\mu\text{g/dL}$	Within 1 Week
45-69 $\mu\text{g/dL}$	Within 48 Hours
>70 $\mu\text{g/dL}$	Immediately

We ask that you make every effort to obtain a timely venous confirmation for children with unconfirmed elevated capillary results. Should you have questions or believe that we can be of any assistance to you relative to following-up with this or any other unconfirmed cases that you might have, please do not hesitate to call.

Sincerely,  
Healthy Homes and Lead Poisoning Prevention Program

Fingerstickfollowup.dot Revised 7/12

State of Rhode Island and Providence Plantations  
Childhood Lead Poisoning Prevention Program  
Lead Inspection Referral Form

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Child's Name:

DOB:

Client Case ID:

Env Case ID:

Address to Inspect:

Insurance:

Parent/Guardian:

**Inspector Information**

Comments: Send original inspection report to DOH, hard copy to parent via certified mail/return receipt, and email to the lead center contact below.

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**Case Management Agency**

Comments: Please provide above inspector with assigned Case Manager's name & contact information.

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Reason for Referral:

**Provider Information**

Provider Name:

Address:

**Lead Program Contact and Deadline**

Date referral processed:

DOH contact:

Date referral sent to inspector:

Email:

Inspector response deadline:

Office:

**Inspector Response**

Inspection scheduled for: \_\_\_\_\_ at \_\_\_\_\_ am/pm.

\_\_\_\_\_ Inspection not scheduled

1. Attempts to reach the family include:

\_\_\_\_\_

\_\_\_\_\_

3. I will keep working on this case and notify DOH via email if the attempts remain unsuccessful. \_\_\_\_\_

4. I am no longer working on this case because:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_